

## HIV COUNSELING INFORMATION FORM

## Administrative Information

Agency/  
LHD no.: Site no.: Clinic type: (mark one ☒)

- ☐ (1) Alternative test site    ☐ (8) Street outreach  
☐ (2) Family planning    ☐ (9) Mobile van  
☐ (3) STD clinic    ☐ (10) TB clinic  
☐ (4) Alc./drug treatment    ☐ (11) Youth drop in  
☐ (5) Detention facility    ☐ (12) Other health department  
☐ (6) Primary care/CHC    ☐ (13) Other, specify: \_\_\_\_\_  
☐ (7) HIV test

Client's test election: (mark one ☒)

- ☐ (1) Tested anonymously  
☐ (2) Tested confidentially  
☐ (3) Declined testing/not tested

## Counseling Dates

(date and initial)

Risk assessment:

Service Date (mm/dd/yy)

Initials (print)

Follow-up contact:

(to reset missed disclosure/post disclosure sessions by confidential clients)

Disclosure session:

(this may be the same date as risk assessment for rapid test results)

(carefully verify anonymous clients using *Client Information*)☐ (1) Mark ☒ if post disclosure counseling scheduled.

Post disclosure session:

(for rapid test positive confirmatory disclosures and post disclosure)

(carefully verify anonymous clients using *Client Information*)Unique Office of AIDS  
Client NumberFirst letter of  
last name: Enter first letter of last name.  
Mark "\*" if declined/refused.Alternative billing:  
(mark all that apply ☒)

- ☐ (1) No billing to OA  
☐ (1) Risk Assessment  
☐ (1) Disclosure  
☐ (1) Post Disclosure  
☐ (1) Laboratory Work

Detuned: (studies only)

- ☐ (1) DTR (recent)  
☐ (2) DTL (long standing)  
☐ (3) DTNT (not tested)

## Client Information

Race/ethnicity: (mark one or two ☒)

- ☐ (1) ☐ (1) African American (not Hispanic)  
☐ (2) ☐ (2) American Indian/Alaskan Native  
☐ (3) ☐ (3) Asian/Pacific Islander  
☐ (4) ☐ (4) Hispanic/Latino(a)  
☐ (5) ☐ (5) White (not Hispanic)  
☐ (6) ☐ (6) Other, specify: \_\_\_\_\_

Date of birth:  
(mm/dd/yy)Gender and pregnancy: (mark one ☒)

- ☐ (1) Male  
☐ (2) Female  
☐ (3) Pregnant female  
☐ (4) Transgendered: male to female  
☐ (5) Transgendered: female to male  
☐ (6) Other, specify: \_\_\_\_\_

Sexual orientation: (mark one ☒)

- ☐ (1) Heterosexual (straight)  
☐ (2) Bisexual  
☐ (3) Gay, lesbian, queer, or homosexual  
☐ (4) Other, specify: \_\_\_\_\_  
☐ (5) Client doesn't know

Residence county:

Residence zip code: ☐ (1) Mark ☒ if client is homeless.Client was referred by: (mark one ☒)

- ☐ (1) HIV+ partner  
☐ (2) PCRS/partner notification  
☐ (3) OA NIGHT outreach (incentive/referral)  
☐ (4) Other outreach worker  
☐ (5) HIV education program  
☐ (6) AIDS telephone hotline  
☐ (7) Other AIDS agency  
☐ (8) Alcohol/drug treatment program  
☐ (9) M.D./health clinic  
☐ (10) Friend/relative  
☐ (11) Media (TV, radio, print)  
☐ (12) Internet  
☐ (13) No identifiable referral source

Client's reason for testing: (mark one ☒)

- ☐ (1) Reconfirming HIV+ result  
☐ (2) Reports AIDS-like symptoms  
☐ (3) Has current HIV+ partner  
☐ (4) Had past HIV+ partner  
☐ (5) TB diagnosis  
☐ (6) STD related  
☐ (7) Hepatitis diagnosis  
☐ (8) Pregnancy  
☐ (9) Risky behavior  
☐ (10) Starting a new relationship  
☐ (11) Partner request  
☐ (12) Rape/assault  
☐ (13) Exposure to blood  
☐ (14) Immigration  
☐ (15) Other, specify: \_\_\_\_\_

## HIV Testing History

Number of prior HIV tests: (circle one)

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9+)

Date of last test result: (mm/yy)

Last test result: (mark one ☒)

- ☐ (1) Positive  
☐ (2) Negative  
☐ (3) Inconclusive  
☐ (4) Did not return for results

## Risk Reduction Steps

Risk assessment stage of change: (mark one ☒)

- ☐ (1) Not thinking about it (Precontemplation)  
☐ (2) Thinking about it (Contemplation)  
☐ (3) Ready for action (Preparation)  
☐ (4) Action  
☐ (5) Maintenance

Immediate risk reduction step:

(to be accomplished by client before disclosure)

At disclosure: risk reduction step(s): (mark one ☒)

- ☐ (1) No step established at risk assessment  
☐ (2) Client made no effort  
☐ (3) Step attempted  
☐ (4) Step achieved

Post disclosure/short-term risk reduction step(s):

Long-term risk reduction step(s):

## Referrals

Client referrals:

Record at risk assessment (RA), disclosure (D) and post disclosure (PD). Order by marking 1 for your primary referral. Other referrals should be numbered 2 and 3.

	RA	D	PD
(1) NONE			
(2) Referral list only			
(3) Other HIV testing			

Risk/harm reduction

(4) Prevention case management (PCM)			
(5) HIV education & prevention services			
(6) Follow-up HIV counseling			
(7) Prevention skill development			
(8) Prevention support group			
(9) Individual psychotherapy/counseling			

Substance use services

(10) Alcohol/drug treatment			
(11) Twelve step program			
(12) Needle exchange program			

HIV positive referrals

(13) Early intervention program (EIP)			
(14) HIV case management			
(15) HIV medical care/evaluation/treatment			
(16) PCRS/partner notification			

Other referrals

(17) Post-exposure prophylaxis (PEP)			
(18) Hepatitis testing/vaccination			
(19) STD clinic			
(20) Reproductive health services			
(21) Other Non-HIV medical services			
(22) Social services			
(23) Other, specify: _____			

Counselor: Review/Assess Introductory Issues

- ☐ Anonymity/confidentiality/non-names testing.  
☐ Risk assessment process and purpose of form.  
☐ What the HIV test measures.  
☐ Meaning/accuracy of test results  
 (preliminary positive, positive, negative, inconclusive).  
☐ Impact of HIV on the immune system.

Counselor: Review/Assess Testing Issues

- ☐ Window period/date of any follow-up test.  
☐ Process of testing.  
☐ Coping with waiting for test results.  
☐ Client's readiness to be tested.  
☐ Offer testing, if appropriate.  
☐ Encourage the client to return for results.

Counselor Notes:

Discuss and record the client's behavior during the **last two years** unless otherwise indicated. If client has received an HIV test result during the last two years then discuss and record the client's behavior since the date of the client's last test result.

**Date of last test result:** (if within last 2 years) \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/yy) (from HIV Testing History on front of form)

### Sexual Risk History (last 2 years/last result)

<b>Total number of sex partners:</b> (last 2 years/last result) (000-999) <input type="text"/>				
<b>Male sex partner(s).</b>				
<b>Partner(s):</b> (mark one <input type="checkbox"/> )	<b>Sexual activity:</b>	<b>Frequency of barrier use:</b>		
<input type="checkbox"/> (0) no partners	Oral <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Yes	No	TFC
<input type="checkbox"/> (1) one or more	Vaginal <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Never	Sometimes	Always
<input type="checkbox"/> (*) declined/refused	Anal insertive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<b>Female sex partner(s).</b>				
<b>Partner(s):</b> (mark one <input type="checkbox"/> )	<b>Sexual activity:</b>	<b>Frequency of barrier use:</b>		
<input type="checkbox"/> (0) no partners	Oral <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Yes	No	TFC
<input type="checkbox"/> (1) one or more	Vaginal <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Never	Sometimes	Always
<input type="checkbox"/> (*) declined/refused	Anal insertive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<b>Transgendered partner(s).</b>				
<b>Partner(s):</b> (mark one <input type="checkbox"/> )	<b>Sexual activity:</b>	<b>Frequency of barrier use:</b>		
<input type="checkbox"/> (0) no partners	Oral <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Yes	No	TFC
<input type="checkbox"/> (1) one or more	Vaginal <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Never	Sometimes	Always
<input type="checkbox"/> (*) declined/refused	Anal insertive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<b>Sex with sex worker(s)/prostitute(s).</b>				
<b>Partner(s):</b> (mark one <input type="checkbox"/> )	<b>Sexual activity:</b>	<b>Frequency of barrier use:</b>		
<input type="checkbox"/> (0) no partners	Oral <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Yes	No	TFC
<input type="checkbox"/> (1) one or more	Vaginal <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Never	Sometimes	Always
<input type="checkbox"/> (*) declined/refused	Anal insertive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<b>Sex partner(s) who injected drugs or other substances.</b>				
<b>Partner(s):</b> (mark one <input type="checkbox"/> )	<b>Sexual activity:</b>	<b>Frequency of barrier use:</b>		
<input type="checkbox"/> (0) no partners	Oral <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Yes	No	TFC
<input type="checkbox"/> (1) one or more	Vaginal <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Never	Sometimes	Always
<input type="checkbox"/> (*) declined/refused	Anal insertive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<b>HIV-infected sex partner(s).</b>				
<b>Partner(s):</b> (mark one <input type="checkbox"/> )	<b>Sexual activity:</b>	<b>Frequency of barrier use:</b>		
<input type="checkbox"/> (0) no partners	Oral <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Yes	No	TFC
<input type="checkbox"/> (1) one or more	Vaginal <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Never	Sometimes	Always
<input type="checkbox"/> (*) declined/refused	Anal insertive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
	Anal receptive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<b>Did client know partner's HIV-positive status prior to sexual contact?</b> <input type="checkbox"/> (1) <input type="checkbox"/> (0)				
<b>(Females Only) Male partner(s) who has had sex with a male.</b>				
<b>Partner(s):</b> (mark one <input type="checkbox"/> )	<b>Sexual activity:</b>	<b>Frequency of barrier use:</b>		
<input type="checkbox"/> (0) no partners	Oral <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Yes	No	TFC
<input type="checkbox"/> (1) one or more	Vaginal <input type="checkbox"/> (1) <input type="checkbox"/> (0)	Never	Sometimes	Always
<input type="checkbox"/> (*) declined/refused	Anal receptive <input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)

### Optional Data

<b>Item 1:</b>	<b>Item 3:</b>
<b>Item 2:</b>	<b>Item 4:</b>

### Counselor: Review/Assess Basic Issues

- |                                                                                      |                                                                   |
|--------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Discuss safer sex guidelines.                               | <input type="checkbox"/> Demonstrate proper condom/barrier use.   |
| <input type="checkbox"/> Role-play with client to build needed skills.               | <input type="checkbox"/> Discuss obstacles to condom/barrier use. |
| <input type="checkbox"/> Partner risks as they relate to client risk.                | <input type="checkbox"/> Cultural/peer influences.                |
| <input type="checkbox"/> Risk reduction communication with partner.                  | <input type="checkbox"/> Domestic violence/sexual assault.        |
| <input type="checkbox"/> Integration of birth control & risk reduction.              | <input type="checkbox"/> Voluntary PCR/S/partner notification.    |
| <input type="checkbox"/> Pregnancy/maternal transmission (utero, birth, breastfeed). |                                                                   |

### Substance Use History (last 2 years/last result) ☐ (\*) declined/refused

<b>Substance use:</b> (mark all that apply <input type="checkbox"/> )	<b>Injected:</b>	<b>Frequency used with sex:</b>			
<input type="checkbox"/> (1) no alcohol or drug use	Yes No	Never	Rarely	Sometimes	Usually
<input type="checkbox"/> (1) alcohol	<input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) marijuana (pot, grass, weed, hash)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) heroin, etc. (junk, skag, smack, H)	<input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) barbiturate/tranquilizers	<input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) crack (rock)	<input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) amphetamine (crank, crystal, tina)	<input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) cocaine (powder)	<input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) nitrate/nitrite (poppers, rush)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) ecstasy (MDMA, Adam, E, X)	<input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) GHB (liquid ecstasy, gina, G)	<input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) ketamine (special K, K)	<input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) Viagra (Cialis, Levitra, Meltabs, Caverta, Generic - Viagra, Cialis, & Levitra)		<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) hallucinogens (LSD, acid, psilocybin, peyote, mescaline, PCP)	<input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<input type="checkbox"/> (1) other, specify: _____	<input type="checkbox"/> (1) <input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
<b>Injection behaviors: (complete if injected)</b>					
Never Sometimes Always TFC					
Shared needles <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3)		Shared with a known HIV+ partner? <input type="checkbox"/> (1) <input type="checkbox"/> (0)			
Cleaned works <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3)					
Needle exchange <input type="checkbox"/> (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3)		Is NE available in client's area? <input type="checkbox"/> (1) <input type="checkbox"/> (0)			
<b>Needle/syringe sources: (mark all that apply <input type="checkbox"/>)</b>					
<input type="checkbox"/> (1) needle exchange program		<input type="checkbox"/> (1) needle dealer/seller		<input type="checkbox"/> (1) close friend	
<input type="checkbox"/> (1) secondary exchange		<input type="checkbox"/> (1) shooting gallery		<input type="checkbox"/> (1) sexual partner	
<input type="checkbox"/> (1) pharmacy/drug store		<input type="checkbox"/> (1) diabetic		<input type="checkbox"/> (1) other source	
<b>IDU treatment history</b>					
Never <input type="checkbox"/> (1)		Currently in treatment <input type="checkbox"/> (2)	Within last 2 yrs/last result <input type="checkbox"/> (3)	Prior to last 2 yrs/last result <input type="checkbox"/> (4)	TFC

### Other Risk History

<b>STDs/hepatitis (last 2 years/last result): (mark all that apply <input type="checkbox"/>)</b> <input type="checkbox"/> (*) declined/refused		
<input type="checkbox"/> (1) no STDs/hepatitis	<input type="checkbox"/> (1) genital/anal warts (HPV)	
<input type="checkbox"/> (1) syphilis (syph, the pox, lues)	<input type="checkbox"/> (1) genital herpes (HSV)	
<input type="checkbox"/> (1) gonorrhea urethral (GC, clap, drip)	<input type="checkbox"/> (1) hepatitis A (HAV)	
<input type="checkbox"/> (1) gonorrhea oral (GC, clap, drip)	<input type="checkbox"/> (1) hepatitis B (HBV)	
<input type="checkbox"/> (1) gonorrhea anal/rectal (GC, clap, drip)	<input type="checkbox"/> (1) hepatitis C (HCV)	
<input type="checkbox"/> (1) chlamydia	<input type="checkbox"/> (1) other, specify: _____	
<input type="checkbox"/> (1) trichomoniasis (trich)		
<b>Viral STDs/hepatitis (lifetime history): (mark all that apply <input type="checkbox"/>)</b> <input type="checkbox"/> (*) declined/refused		
<input type="checkbox"/> (1) no lifetime viral STDs/hepatitis	<input type="checkbox"/> (1) hepatitis A (HAV)	
<input type="checkbox"/> (1) genital/anal warts (HPV)	<input type="checkbox"/> (1) hepatitis B (HBV)	
<input type="checkbox"/> (1) genital herpes (HSV)	<input type="checkbox"/> (1) hepatitis C (HCV)	
<b>Hepatitis vaccination (lifetime history): (mark one each <input type="checkbox"/>)</b>		
Completed vaccination series for hepatitis A (HAV)?	Yes <input type="checkbox"/> (1)	No <input type="checkbox"/> (0) <input type="checkbox"/> (*) declined/refused
Completed vaccination series for hepatitis B (HBV)?	<input type="checkbox"/> (1)	<input type="checkbox"/> (0) <input type="checkbox"/> (*) declined/refused
<b>Other risk factors (last 2 years/last result): (mark one each <input type="checkbox"/>)</b>		
Received money/other items or services for sex.	Yes <input type="checkbox"/> (1)	No <input type="checkbox"/> (0) <input type="checkbox"/> (*) declined/refused
Received drugs for sex.	<input type="checkbox"/> (1)	<input type="checkbox"/> (0) <input type="checkbox"/> (*) declined/refused
Behavior resulting in other blood-to-blood contact (SM, tattooing, piercing, cuts, etc.) or that allows blood contact with mouth, vagina or anus.	<input type="checkbox"/> (1)	<input type="checkbox"/> (0) <input type="checkbox"/> (*) declined/refused
Shared objects/fingers inserted in mouth, vagina or anus.	<input type="checkbox"/> (1)	<input type="checkbox"/> (0) <input type="checkbox"/> (*) declined/refused
Blood-to-blood exposure on the job.	<input type="checkbox"/> (1)	<input type="checkbox"/> (0) <input type="checkbox"/> (*) declined/refused
Job exposure blood known to be HIV+.	<input type="checkbox"/> (1)	<input type="checkbox"/> (0) <input type="checkbox"/> (*) declined/refused
Blood/blood product transfusion before 1985 (or in a country where blood is/was not tested for HIV).	<input type="checkbox"/> (1)	<input type="checkbox"/> (0) <input type="checkbox"/> (*) declined/refused
Child born of an HIV-infected woman.	<input type="checkbox"/> (1)	<input type="checkbox"/> (0) <input type="checkbox"/> (*) declined/refused
Other behavior, specify: _____	<input type="checkbox"/> (1)	<input type="checkbox"/> (0) <input type="checkbox"/> (*) declined/refused

### Counselor: Review/Assess Drug and STD Issues

- |                                                                                                   |                                                                    |
|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Prevention/harm reduction/safer sex with IDUs.                           | <input type="checkbox"/> Demonstrate proper needle cleaning.       |
| <input type="checkbox"/> Explore alcohol & drug treatment/recovery.                               | <input type="checkbox"/> Drugs with sex as co-factor for HIV risk. |
| <input type="checkbox"/> Behaviors affecting other STDs (eg. rimming).                            | <input type="checkbox"/> STDs as a co-factor for HIV risk.         |
| <input type="checkbox"/> Health effects of concurrent STD/HIV (e.g. pelvic inflammatory disease). |                                                                    |

**Time Frame Code (TFC): (studies only)** 6 = within past 6 months 1 = within past 12 months  
2 = within past 2 years + = greater than 2 yrs 9 = unknown \* = declined/refused